NEVADA STATE BOARD OF MEDICAL EXAMINERS

FEES FOR PERFUSIONIST LICENSURE

BETWEEN JULY 1, 2013 AND JUNE 30, 2015

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on single-sided, white bond paper, 8 ½" x 11" in size.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

Fees applicable July 1, 2013 – June 30, 2014:
$300 Application Fee $400 Registration Fee $75 Criminal Background Investigation Fee = $775.00

Fees applicable July 1, 2014 – June 30, 2015:
$300 Application Fee $200 Registration Fee $75 Criminal Background Investigation Fee = $575.00

You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

The Application fee and Criminal Background Investigation fee will not be refunded.

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances** warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a 13, 14, 21, 22, 23, 24, 25 and/or 26.

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

There are **NO** waivers or exceptions to the requirements for perfusionist licensure in the state of Nevada.

Revised 2/15/2013

PERFUSIONIST

APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT

_____	a.	APPLICATION: ☐ Properly completed, signed and notarized application, including pages 1 – 4, Applicant Responsibility statement, and Criminal Background Investigation report authorization form; ☐ Recent passport quality photograph (at least 2"x 2") attached to application, signed in ink on lower front edge; ☐ Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 14, 21, 22, 23, 24, 25, and 26; ☐ Release form - signed and notarized (Form A);
_____	b.	FEES: • Proper application, registration, AND criminal background investigation fees – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. Note: Application and criminal background investigation fees are non-refundable;
_____	c.	IDENTITY (important identity documents will be returned to you via secured mail): • U.S. born citizens – Original or Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable); • Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport; • Non U.S. citizens - Copy of both sides of Alien Registration card; Employment Authorization card; or Visa;
_____	d.	SELF-QUERY VERIFICATION: • Self-query response from the National Practitioner Data Bank (NPDB); see enclosed instruction sheet. The NPDB will send the report directly to you and you will forward the final report to the Board office; The request form for the National Practitioner Data Bank (NPDB) is available at http://www.npdb.hrsa.gov. Click on "How to Get Started" under the Practitioners column on the left side of the page and follow the instructions provided. If you require additional information, please call the NPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office.
_____	e.	SUPPLEMENTARY FORM: • MALPRACTICE INSURANCE CARRIER (Form B): ONLY if you have answered affirmatively to either of the two malpractice questions (questions #12 and #12a) on the application;
_____	f.	EDUCATION: ☐ Copy of high school transcripts or diploma; ☐ Copy of transcripts or diplomas for degrees other than Perfusionist degree – an Associates, Bachelors or Masters Degree that you would like added to your educational profile on the Board's website;
_____	g.	NOTIFICATION OF PRACTICE LOCATION: • Notification of Practice Location form signed and dated;
_____	h.	NOTIFICATION OF SUPERVISING PERFUSIONIST(S) (required for Temporary Perfusionist only): • Notification of Nevada Licensed Supervising Perfusionist(s) form signed and dated;
_____	i.	CONTINUING EDUCATION: ☐ Review guidelines of the Centers for Disease Control and Prevention concerning the transmission of infectious agents through safe injection practices (you will be required to attest within the application that you have reviewed these guidelines); http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

PERFUSIONIST

APPLICATION CHECKLIST

DIRECT SOURCE VERIFICATIONS
TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN BY THE VERIFYING INSTITUTION TO BOARD OFFICE

Verifying agencies may charge a fee. ***Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.***

_____	a.	PERFUSIONIST SCHOOL: ☐ Verification of completion of accredited perfusionist program (Form 1); ☐ Official transcripts from perfusionist program. If trained on the job (grandfathered into your position as a perfusionist), please provide copies of supporting documentation or certificates which so indicate. If no such document(s) exist, provide a notarized statement indicating your training experience (who, what, where, when, why);
_____	b.	EXAMINATION: • Current certification by the American Board of Cardiovascular Perfusion (Form 2);
_____	c.	STATE LICENSE VERIFICATIONS: • Verification of licensure/certification from ALL states where applicant is currently licensed/certified or has ever been licensed/certified (Form 3) [does not include training licenses or temporary permits];
_____	d.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: • Malpractice insurance carrier verification (Form 4) to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that occurred within the past 10 years (see Disclaimer below);
_____	e.	FINGERPRINTS: • FBI Criminal history background report – returned directly by the verifying institution to the Board office. **(Once application fees have been received, a fingerprint card and instructions will be mailed to the applicant. Note: The Board fingerprint card contains the necessary Board account numbers required for processing.)**

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

Nevada Revised Statutes – Perfusionist Licensure

I. "Perfusion" means the performance of functions which are necessary to provide for the support, treatment, measurement or supplementation of a patient's cardiovascular, circulatory or respiratory system or other organs, or any combination of those activities, and to ensure the safe management of the patient's physiological functions by monitoring and analyzing the parameters of the patient's systems or organs under the order and supervision of a physician.

(a) The term includes, without limitation:

1. The use of extracorporeal circulation and any associated therapeutic and diagnostic technologies; and

2. The use of long-term cardiopulmonary support techniques.

(b) As used in this section, "extracorporeal circulation" means the diversion of a patient's blood through a heart-lung bypass machine or a similar device that assumes the functions of the patient's heart, lungs, kidney, liver or other organs.

II. "Perfusionist" means a person who is licensed to practice perfusion by the Board.

III. "Temporarily licensed perfusionist" means a person temporarily licensed to practice perfusion by the Board.

IV. To be eligible for licensing by the Board as a perfusionist, an applicant must:

(a) Be a natural person of good moral character;

(b) Submit a completed application as required by the Board;

(c) Submit any required fees;

(d) Have successfully completed a perfusion education program approved by the Board, which must:

(1) Have been approved by the Committee on Allied Health Education and Accreditation of the American Medical Association before June 1, 1994; or

(2) Be a program that has educational standards that are at least as stringent as those established by the Accreditation Committee-Perfusion Education and approved by the Commission of Accreditation of Allied Health Education Programs of the American Medical Association, or its successor;

(e) Pass an examination required by the Board; and

(f) Comply with any other requirements set by the Board.

V. The Board uses the certification examinations given by the American Board of Cardiovascular Perfusion, or its successor, in determining the qualifications for granting a license to practice perfusion.

VI. The Board shall waive the examination required pursuant to paragraph V, for an applicant who at the time of application:

(a) Is licensed as a perfusionist in another state, territory or possession of the United States, if the requirements for licensure are substantially similar to those required by the Board; or

(b) Holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion, or its successor, before October 1, 2009.

VII. The Board shall issue a license as a perfusionist to each applicant who proves to the satisfaction of the Board that the applicant is qualified for licensure. The license authorizes the applicant to represent himself as a licensed perfusionist and to practice perfusion in the State of Nevada subject to the conditions and limitations of this chapter.

(a) Each licensed perfusionist shall:

(1) Display his current license in a location which is accessible to the public;

(2) Keep a copy of his current license on file at any health care facility where he provides services; and

(3) Notify the Board of any change of address in accordance with NRS 630.254.

(b). As used in this section, "health care facility" means a medical facility or facility for the dependent licensed pursuant to chapter 449 of NRS.

VIII. Each perfusionist license issued by the Board expires on July 1 of every odd-numbered year and may be renewed if, before the license expires, the holder of the license submits to the Board:

(1) A completed application for renewal on a form prescribed by the Board;

(2) Proof of his completion of the requirements for continuing education prescribed by regulations adopted by the Board; and

(3) The applicable fee for renewal of the license prescribed by the Board.

(a) A license that expires pursuant to this section not more than 2 years before an application for renewal is made is automatically suspended and may be reinstated only if the applicant complies with the provisions required by the Board;

(b) If a license has been expired for more than 2 years, a person may not renew or reinstate the license but must apply for a new license and submit to the examination required by the Board.

(c) The Board shall send a notice of renewal to each licensee not later than 60 days before his license expires. The notice must include the amount of the fee for renewal of the license.

IX. The Board may issue a temporary license to practice perfusion in this State to a person who has not yet completed the examination required by the Board but who has:

(1) Has completed an approved perfusion education program;

(2) Files an application; and

(3) Pays the required fee.

(a) A perfusionist shall supervise and direct a temporarily license perfusionist at all times during which the temporarily licensed perfusionist performs perfusion.

(b) A temporary license is valid for 1 year after the date it is issued and may be extended subject to regulation by the Board. The application for renewal must be signed by a supervising licensed perfusionist.

(c) If a temporarily license perfusionist fails any portion of the examination, he shall immediately surrender the temporary license to the Board.

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:

NRS 630.301 Criminal offenses; disciplinary action taken by other jurisdiction; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.
2. Conviction of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310, or 616D.350 to 616D.440, inclusive.
3. Any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by another state, the Federal Government, a foreign country or any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.
4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if the malpractice is established by a preponderance of the evidence.
5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.
6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.
7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.
8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when the failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.
9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics.
10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.
11. Conviction of:

(a) Murder, voluntary manslaughter or mayhem;
(b) Any felony involving the use of a firearm or other deadly weapon;
(c) Assault with intent to kill or to commit sexual assault or mayhem;
(d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
(e) Abuse or neglect of a child or contributory delinquency;
(f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or
(g) Any offense involving moral turpitude.

(Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, 766; 2003, 2707, 3433; 2003, 20th Special Session, 264, 265; 2005, 2522; 2007, 3045; 2011, 847)

NRS 630.304 Misrepresentation in obtaining or renewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.
2. Advertising the practice of medicine in a false, deceptive or misleading manner.
3. Practicing or attempting to practice medicine under another name.
4. Signing a blank prescription form.
5. Influencing a patient in order to engage in sexual activity with the patient or with others.
6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.
7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.

(Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

(a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.
(b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.
(c) Referring, in violation of NRS 439B.425, a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.
(d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.
(e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.
(f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.
(g) Failing to disclose to a patient any financial or other conflict of interest.
(h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for the licensee's medical education.

2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of NRS 636.373.

(Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065 (cont.):

NRS 630.306 Inability to practice medicine; deceptive conduct; violation of regulation governing practice of medicine or adopted by State Board of Pharmacy; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient or patient's family; lack of skill or diligence; habitual intoxication or dependency on controlled substances; filing of false report; failure to report certain changes of information or disciplinary or criminal action in another jurisdiction; failure to be found competent after examination; certain operation of a medical facility; prohibited administration of anesthesia or sedation; engaging in unsafe or unprofessional conduct; knowingly procuring or administering certain controlled substances or dangerous drugs; failure to supervise medical assistant adequately. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
2. Engaging in any conduct:

(a) Which is intended to deceive;

(b) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or

(c) Which is in violation of a regulation adopted by the State Board of Pharmacy.

3. Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law.
4. Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
5. Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training.
6. Performing, without first obtaining the informed consent of the patient or the patient's family, any procedure or prescribing any therapy which by the current standards of the practice of medicine is experimental.
7. Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
8. Habitual intoxication from alcohol or dependency on controlled substances.
9. Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
10. Failing to comply with the requirements of NRS 630.254.
11. Failure by a licensee or applicant to report in writing, within 30 days, any disciplinary action taken against the licensee or applicant by another state, the Federal Government or a foreign country, including, without limitation, the revocation, suspension or surrender of a license to practice medicine in another jurisdiction.
12. Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.
13. Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318.
14. Operation of a medical facility at any time during which:

(a) The license of the facility is suspended or revoked; or

(b) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.

➥ This subsection applies to an owner or other principal responsible for the operation of the facility.

15. Failure to comply with the requirements of NRS 630.373.
16. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board.
17. Knowingly procuring or administering a controlled substance or a dangerous drug as defined in chapter 454 of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:

(a) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;

(b) Was procured through a Canadian pharmacy which is licensed pursuant to chapter 639 of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of NRS 639.2328; or

(c) Is marijuana being used for medical purposes in accordance with chapter 453A of NRS.

18. Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962; 2011, 257, 2612)

NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
2. Altering medical records of a patient.
3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.
4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.
5. Failure to comply with the requirements of NRS 630.3068.
6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.

(Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433; 2009, 2963)

NRS 630.3065 Willful disclosure of privileged communication; willful failure to comply with statute or regulation governing practice of medicine. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Willful disclosure of a communication privileged pursuant to a statute or court order.
2. Willful failure to comply with:

(a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;

(b) A court order relating to this chapter; or

(c) A provision of this chapter.

3. Willful failure to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of NRS 439B.410.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302)

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during your training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

○ ○ ○ ○ ○

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name _____

Sign your name _____

Date _____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

7/1/2013 – 6/30/2015

Date Received by Board

APPLICATION FOR PERFUSIONIST LICENSURE

License No._____

NEVADA STATE BOARD OF MEDICAL EXAMINERS

File No._____

P.O. Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 (For Board Use Only)
Physical Address: 1105 Terminal Way, Ste. 301 Reno, Nevada 89502

1. Present Legal Name _____
Last First Middle Maiden

List any other name ever used _____

Address:

The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.

The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address _____
Street City County State Zip

☐ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. Telephone Numbers _(_____)_____ _(_____)_____ _(_____)_____ _(_____)_____
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth _____ Place of Birth _____ Gender ☐ F ☐ M
(Month – Day – Year) (City – State – Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____ Employment Authorization # _____ Visa _____

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card, or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number *_____ Height _____ Weight _____ Color of Eyes _____ Color of Hair _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine, to practice as a perfusionist shall include the social security number of the applicant in the application submitted to the Board.
NAC 700(2)(c) An applicant must submit such further evidence and other documents or proof of qualifications as are required by the Board.
NRS 630.173(2) The Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice as a perfusionist" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice as a perfusionist with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice as a perfusionist, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice as a perfusionist with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? (IF ANSWER IS "YES", YOU MUST COMPLETE FORM B AND FORM 6 – see Application Checklist.)
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

12a. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances?* Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

14. Have you previously applied for perfusionist licensure in Nevada?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

(All information must begin on the application, if more space is needed, please attach separate sheet.)

15. List all schools attended (including high school), type of degree received and dates of attendance.

Name	City/State	Type of Degree Received	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)

16. Perfusionist Certificate / Degree granted by:

Perfusionist School	City / State	Exact Date of Issuance

17. Account for, in chronological order, all activities (professional practice and other non-professional activities) since graduation from Perfusionist School. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.**

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a perfusionist in any state, territory or country.

State/Territory	License #	Date of Issuance (Mo./Yr.)	Date of Expiration (Mo./Yr.)

19. List below the requested information for all hospitals or surgery centers in which you **ARE employed, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

20. Are you currently certified by the American Board of Cardiovascular Perfusion? _____Yes _____No

If "Yes:" certification number _____ certification expires _____

If "No:" date scheduled to sit for the examination _____

21. Have you ever been denied a license or certificate to practice as a perfusionist, or in any other healing art, or permission to take an examination to practice as a perfusionist or in any other healing art(s) in any state, country or U.S. territory?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

22. Have you ever had a perfusionist license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

23. Have you ever voluntarily surrendered a license or certificate to practice as a perfusionist, or in any other healing art, in any state, country or U.S. territory?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

24. Have you ever failed the ABCP examination, or any state or other jurisdiction examination for certification as a perfusionist?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

25. Have you ever been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a perfusionist by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

26. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (<u>Please Note</u>: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(If more space is needed, please attach separate sheet .)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. _____Yes _____No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR <u>APPLICANT</u> PERFUSIONIST

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

Applicant: _____ Date: _____

APPLICANT PHOTOGRAPH:

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

_____ _____
Signature of applicant **Date**

APPLICATION AFFIRMATION

I, _____,
(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

_____ _____
Signature of applicant **Date**

State of _____ County of _____
Subscribed and sworn to before me this _____ day of
_____, 2_____.
Notary Public for the State of _____
My Commission Expires: _____
Residing at: _____
City State

(NOTARY SEAL)

_____
Signature of Notary

PERFUSIONIST

Notification of Practice Location

Pursuant to Nevada Administrative Code Chapter 630, before providing perfusion services, a Perfusionist must notify the Board of the name and location of the primary location of practice.

Please type or print clearly.

I, _____, hereby notify the Nevada State Board of Medical Examiners that I will be working at:

_____

_____

_____

Practice Location(s) Telephone Number

You may use an extra page, if necessary.

_____

Print your name

_____

Signature

_____

Date

TEMPORARY PERFUSIONIST

Notification of Supervising Perfusionist(s)

Pursuant to Nevada Administrative Code Chapter 630.2696 (2), a perfusionist shall supervise and direct a temporarily licensed perfusionist at all times during which the temporarily licensed perfusionist performs perfusion.

Please type or print clearly.

I, _____, hereby notify the Nevada State Board of Medical Examiners that my Nevada licensed supervising perfusionist(s) is/are:

_____

_____

_____

Perfusionist's Name License number Telephone Number

You may use an extra page, if necessary.

_____
Print your name

_____
Signature

_____
Date

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

(NOTARY SEAL)

_____
Signature of Notary

A photocopy of this form will serve as an original.

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
or
1105 Terminal Way, Ste. 301
Reno, NV 89502

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

Name of Insured: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

(If more space is needed, please copy this page or attach a separate sheet.)

Applicant: ***Each school where perfusionist education was received must complete this form. If more than one school, photocopies of this blank form may be made and used.***

FORM 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
PERFUSIONIST EDUCATION VERIFICATION

I certify that _____
(name of applicant)

DOB:_____ SSN:_____

The following information to be completed by program only!

was enrolled in: _____
(name of school/program)

located at: _____
(complete address)

from: _____ to _____.
(date of enrollment for Perfusionist Degree) (ending date of attendance for Perfusionist Degree)

The applicant was granted:

_____ Perfusionist Certificate
_____ Perfusionist Degree
_____ Bachelor's Degree
_____ Combined Perfusionist/Bachelor's Degree
_____Combined Perfusionist/Masters Degree
_____ other (please attach explanation)

on the _____ day of _____, _____.
(day) (month) (year)

NOTE: If any portion of this form is deleted or modified, please attach an explanation.

Signed and the institutional seal affixed this

_____ day of _____, 2_____.

Affix seal here

By: _____
(typed name and title of President, Registrar or Dean)

_____
(signature of President, Registrar or Dean)

** Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
(775) 688 – 2559

Applicant: ***This form is to be mailed to the ABCP for completion.***

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
ABCP CERTIFICATION

The American Board of
Cardiovascular Perfusion
207 North 25th Avenue
Hattiesburg, MS 39401
601-582-2227
Fax 601-582-2271
www.abcp.org

Part 1 – to be completed by applicant

I, ____ am in the process
(name of applicant)
of applying for perfusionist licensure in the state of Nevada and hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners.

____
(signature of applicant)

- -

Part 2 – to be completed by ABCP and returned directly to the Nevada State Board of Medical Examiners

I, the undersigned, certify that ____
(name of applicant)
was granted initial certification by the American Board of Cardiovascular Perfusion

on: date issued ____________________________________

certificate number ________________________________.

The above certificate is: ________ current, in good standing ________ not current.

Expiration date of current certification: _____________________________.

Signed and the institutional seal affixed this

________ day of _____________________, 2________

(Affix seal here) By: ____________________________________
(typed name and title of certifying agent)

____
(signature of certifying agent)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
(775) 688 – 2559

Applicant: ***Each state where licensure/certification is or ever was held must complete this form. If more than one state, photocopies of this blank form may be made and used.***

FORM 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF STATE LICENSURE/CERTIFICATION

PART 1 – TO BE COMPLETED BY APPLICANT

Printed Name of Applicant: ____

Address: ____
(street) (apt. or suite #) (city) (state) (zip)

Date of Birth: ____________________
(month) (day) (year)

I am in the process of applying for perfusionist licensure in the state of Nevada. I hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners at the above address.

____
(signature of applicant)

- -

PART 2 – TO BE COMPLETED BY LICENSING AGENCY and returned directly to the Nevada State Board of Medical Examiners

I certify that ____ was
(name of applicant)

granted license/certificate number ____________________ by the state of ________ on ______________________________
(date of issuance)

on the basis of ____.
(examination: NCCPA / State Licensing/Certifying examination)

I certify that the above license/certificate is:

_______ current, in good standing
_______ not current, due to non-payment of fees
_______ subject to pending disciplinary charges
_______ subject to restriction of licensure/certification or practice
_______ other (please attach explanation)

I certify that the records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license/certificate.

NOTE: If any portion of this form is deleted or modified, please attach an explanation.

____
(signature of certifying individual)

____
(title of certifying individual)

____
(licensing/certifying agency name)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
(775) 688 – 2559

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, submit this form to all malpractice carriers verifying all coverage within the past 10 years. If more than one malpractice carrier, photocopies of the blank form may be made and used.

FORM 4

MALPRACTICE CLAIM VERIFICATION REQUEST

Insurance Carrier Information:

Name of Insurance Company: _____

Address:_____

_____

_____

Phone: _____ Fax: _____

(To be completed by verifying agency only)

Policy Number: _____

Policy Period From: _____To: _____

******Please provide a loss history report with this verification.**

Name of Insured

Perfusionist:_____

Policy Number: _____

Policy Period From: _____ To: _____

Claims Experience:

Has this Perfusionist had a settlement paid on his/her behalf?

_____No _____Yes

If "yes", please provide the following information:

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*

Description of Claim:_____

_____

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*

Description of Claim: _____

_____

Insurance Carrier Agent:

_____

Print Name and Title

_____

Telephone

_____

Signature of Agent

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510 (Mailing Address)
1105 Terminal Way, Ste. 301
Reno, NV 89502 (Physical Address)
Phone: (775) 688-2559

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

_____

Perfusionist (applicant) signature and date

Subscribed and sworn to before me this ____ day of _____, 2_____.

By:_____

Notary Public for State of: _____

My Commission Expires: _____

_____

Signature and Seal of Notary Public

PERMISSION TO SEEK
CRIMINAL BACKGROUND INVESTIGATION REPORT
AND TO OBTAIN AND USE A SET OF MY FINGERPRINTS IN THIS REGARD

I understand that all applicants applying for licensure with the Nevada State Board of Medical Examiners, pursuant to Nevada Revised Statutes Chapter 630, must submit a full set of his/her fingerprints, along with an authorization for the Nevada State Board of Medical Examiners to forward his/her fingerprints to the Department of Public Safety Records and Technology Division and to the Federal Bureau of Investigation for a state and federal criminal background investigation and report.

I herewith and hereby grant permission and fully authorize the Nevada State Board of Medical Examiners to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports.

I UNDERSTAND THAT THE COSTS OF FINGERPRINTING, THE BACKGROUND CHECK AND THE REPORT SHALL BE AT MY OWN EXPENSE.

Dated this _____ day of _____, 2_____.

_____

Signature of Applicant

_____

Print Name

By signing my signature on the line below, I do hereby understand that I must timely submit my fingerprints to the Nevada State Board of Medical Examiners in order for the Board to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports. Failure to do so could result in disciplinary action, up to and including immediate summary suspension of my license. NRS 630.167.

_____

Signature of Applicant **Date**

Return this form to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301, Reno, NV 89502
or
P.O. Box 7238
Reno, NV 89510

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510-7238
or fax to:
775-688-2321

***Please type or print legibly*.**

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____
(MM) (YYYY)

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____